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Comment and Response

Advancing health equity for lesbian, gay, bisexual and transgender (LGBT) people through sexual health education and LGBT-affirming health care environments

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Abstract. Lesbian, gay, bisexual and transgender (LGBT) people face pervasive health disparities and barriers to high-quality care. Adequate LGBT sexual health education for emerging health professionals is currently lacking. Clinical training programs and healthcare organisations are well poised to start addressing these disparities and affirming LGBT patients through curricula designed to cultivate core competencies in LBGT health as well as health care environments that welcome, include and protect LGBT patients, students and staff. Health education programs can emphasise mastery of basic LGBT concepts and terminology, as well as openness towards and acceptance of LGBT people. Core concepts, language and positive attitudes can be instilled alongside clinical skill in delivering inclusive sexual health care, through novel educational strategies and paradigms for clinical implementation. Caring for the health needs of LGBT patients also involves the creation of health care settings that affirm LGBT communities in a manner that is responsive to culturally specific needs, sensitivities and challenges that vary across the globe.

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Despite recent advances in the recognition of lesbian, gay, bisexual and transgender (LGBT) people, with data demonstrating a rapid increase in the acceptance of LGBT people[1,2] and attainment of equality in many sectors,[3] education on LGBT health needs for health professionals still lags greatly.[4,5] As recently as a decade ago there were no standard texts that included information about care for LGBT people, and numerous studies and reviews of health issues have documented a continued gap in health care education.[4–7] A study of LGBT topics in medical education published in 2011 showed a median of 5 h of education in both the US and Canada.[8] It is not surprising that despite demonstration of health disparities experienced by LGBT people across the life cycle, many LGBT people find it difficult to access quality care.[6,9] In addition, studies have shown that many LGBT students question being open about their sexual orientation or gender identity when studying to be health professionals due to concerns of bias affecting their professional futures.[10]

These findings point to a need in the area of LGBT health care training for development of core competencies that students can use regardless of their eventual speciality or practice setting,[11] in addition to creating health care environments that are welcoming and affirming for LGBT patients, students and staff.[12,13] Participants in health care settings will only engage effectively and thrive if they can comfortably and openly express their true selves.[10,14,15]

With regard to education, especially in the context of principles of adult learning, existing studies call for developing competencies that encompass critical knowledge, skills and attitudes needed to provide affirmative care to LGBT people.[4–8,11] These cannot be measured in hours, but through comfort with effective communication and patient satisfaction. A curricular resource with suggested milestones has been developed by the Association of American Medical Colleges that can serve as a guide for educational programs seeking to expand LGBT health training.[16] In addition, there are now many more curricular resources for education and training on the health needs of LGBT people than there were just a decade ago,[17,18] including the National LGBT Health Education Center at The Fenway Institute in Boston (www.lgbthealtheducation.org/, accessed 26 January 2017). Of note, achieving satisfactory outcomes with regard to sexual health education in different parts of the world will require tailored approaches that are responsive to unique sociocultural needs, sensitivities and challenges related to sustainable implementation of LGBT-inclusive curricula.[19–22]

Proposed core competencies for health care trainees include the first critical step of ensuring a basic understanding of both

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sexual orientation and gender identity.[23,24] 'Sexual orientation' refers to a person's emotional and physical attraction to others and has three dimensions: identity, behaviour and desire. 'Sexual identity' may be gay, lesbian or bisexual, but other terms like 'queer' are increasingly being used. Sexual behaviour may or may not align consistently with identity. Many men who have sex with men (MSM) identify themselves as heterosexual or straight.[25] For those who identity as queer, which does not imply any particular behaviour, it is important to clarify sexual behaviour during clinical visits in order to provide appropriate care.[26] Finally, many people have sexual desires that are never discussed because they are not given the opportunity to describe these internal experiences in clinical settings, which can lead to a sense of isolation from having no one to talk to regarding frustrated sexual desires.[27,28]

Gender identity is distinct from gender expression, and both are clinically relevant.[29] 'Gender identity' refers to a person's internal sense that they are a man, a woman or, in some cases, both or neither. To the extent that someone's gender identity is non-congruent with their sex assigned at birth, they may identify themselves as transgender or as gender non-binary if they do not identify strictly as either male or female.[24] Gender expression describes a person's outward manifestations of gender in relation to societal norms, such as their style of dress and mannerisms. Gender expression may or may not be related to a person's gender identity. Clinical trainees can be taught to: (1) not make assumptions about a person's gender identity or sexual orientation based on their gender expression; (2) be familiar with commonly used terms, recognising that preferred terminology varies by person, place and time; and (3) have a basic understanding of what the gender affirmation process may entail for transgender people, as well as the medical interventions (i.e. gender-affirming hormones and surgeries) that patients may seek.[22,29]

Notable in recent years is the great expansion of perspectives about both sexual orientation and gender identity.[24] In particular there has been recognition, if not a great deal of research, about the fact that gender identity and sexual orientation can vary in ways that many clinicians have not often observed in the past but now seem to present more openly and frequently.[30–32] Notable are sexual orientations outside the often-described concepts of 'straight', 'lesbian', 'gay' and 'bisexual' and their accompanying behaviours, as well as gender identities that reject the binary paradigm of only 'male' and 'female', thus providing alternative concepts and terminology to describe additional identities that occur along the entire gender spectrum.[24]

These components can all be incorporated into a comprehensive history of sexual health, which would also include discussion of sexual practices, frequency and any desire to have biological children (of particular importance in reproductive planning for patients before beginning gender-affirming hormones),[33] as well as the experience of intimate partner violence.[34]

Some obvious challenges exist with regard to incorporating these best practices for sexual health care, including, in particular, the focus on sexual orientation and gender identity, into an effective educational methodology and implementation of this learning into clinical practice.[33] Sexual histories are by no means conducted routinely,[35] despite their importance in understanding risk of sexually transmissible infections (STIs). Although time constraints are a factor that many cite as a reason for not taking a history of sexual health, so are lack of experience and comfort talking about sexual orientation and gender identity with patients who identify in ways that may be different from the clinician.[5] Fostering these attitudes and skills as part of the educational process will help achieve improvement in talking with patients about sexual health and related intimacy issues. This clinical competency lends itself to assessment via observed patient encounters or the use of simulated patients for teaching purposes.[36,37]

The purpose of talking with patients about sexual orientation and gender identity extends beyond identifying behaviours that may lead to HIV or STIs. These conversations may allow clinical trainees to gain awareness of a wide range of disparities that have been identified in LGBT patients. For example, in addition to learning about disparities pertaining to sexual health (e.g. the increased burden of STIs, including HIV, among MSM[38]), students may grow to appreciate the differential burdens of depression, eating disorders, substance use disorders and homelessness in LGBT populations,[39–42] and understand the relationship between these disparities and the stigma LGBT communities experience.

Improving LGBT health education will necessitate the training of faculty who may have received little to no training in this area during their own education and who may lack experience with or knowledge of LGBT concepts and patient care. This is particularly true because optimal LGBT education is best integrated throughout the clinical curriculum, rather than grouped into a single unit, using cases to illustrate the relevance of sexual orientation and gender identity.[33]

Providing affirmative and welcoming care for LGBT people also involves going beyond educating students and faculty to ensure that healthcare organisations have policies and programs in place to guarantee that LGBT patients, students, faculty and staff feel affirmed, and that students, faculty and staff can feel comfortable to maximally contribute to the organisational mission.[13,14] The National LGBT Health Education Center has identified several key points for organisations seeking to create a truly welcoming and caring environment for LGBT people.[12] These are: active leadership engagement; policies that include and protect LGBT people; engaging the local LGBT community; providing LGBT-affirmative care training for staff; implementing LGBT-inclusive processes, forms and data collection; incorporating LGBT health needs into clinical services; and reflecting the LGBT community through representation in both the physical environment and the workforce. Health organisations certainly differ in their readiness and resources to implement one or more of these systems-level changes, which are therefore likely to occur at different rates from one health system to the next.[19–23] Beyond organisational change within healthcare systems, achieving sustainable and comprehensive health equity for LGBT people will require substantial societal change to address a range of adverse LGBT health outcomes driven by social determinants outside the health care arena.[43]

Conflicts of interest

None declared.

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